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Maine Pediatric and Family Practice Survey Chartbook: Improving Health Outcomes for Children

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Improving Health Outcomes for Children (IHOC)

Maine Pediatric and Family Practice Survey Chartbook

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

Winter 2011-2012



Maine Pediatric and Family Practice Survey Chartbook

Winter 2011-12

Improving Health Outcomes for Children

University of Southern Maine

Muskie School of Public Service

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Executive Summary

In February 2010, Maine and Vermont were awarded a five-year demonstration grant from the Centers for Medicare and Medicaid Services to improve care quality for children who are insured by Medicaid and the Children's Health Insurance Program (CHIP). In Maine, Improving Health Outcomes for Children (IHOC) is a public/private collaboration of health systems, pediatric and family practices, associations, state programs and consumers that is intended to 1) select and promote a set of child health quality measures; 2) build a health information technology infrastructure to support the reporting and use of quality information; and 3) transform the delivery of health services for children using a patient centered medical home model. IHOC provides medical practices with nationally recognized tools and education and quality improvement support through the First STEPS (Strengthening Together Early Preventive Services) learning collaborative to enhance their ability to provide evidence-based care and improve preventive care for children. By aligning and coordinating child health quality infrastructure and quality improvement efforts, IHOC intends to improve access to actionable data for child health providers while reducing their administrative burden, improve care quality, support value-based purchasing, increase early identification of special needs, and ultimately to improve child health outcomes and reduce health care costs.

As part of the IHOC initiative, the University of Southern Maine surveyed pediatric and family practices about how they use data, clinical guidelines and office systems to monitor and improve children's healthcare quality. The purpose of the survey is to provide baseline information about quality improvement activities in primary care practices serving children in Maine. Survey data will be used to inform IHOC activities and to monitor changes over time. The web-based survey was conducted in the winter of 2011-2012 and sent to practice managers at a sample of 168 practice sites, of which 64% responded. Responding practices represent more than one-quarter of family practices and nearly two thirds of all pediatric practices in the state. Together these practices served more than half (57%) of all children insured by MaineCare, or nearly 68,000 MaineCare children. Respondents represent a broad distribution of practices across regions of the state and practice size and ownership, and include nearly two-thirds of practices participating in IHOC's First STEPS learning collaborative.

This report summarizes the results of the initial survey and assesses quality improvement activities in pediatric and family practices at baseline. In 2014, a follow-up survey will be conducted to assess how quality improvement has changed in child-serving practices statewide over time and within specific types of practices (e.g. those participating in First STEPS).

Key highlights from baseline survey results include the following:

Medical Home Recognition and Practice-Level Quality Improvement

- The majority of pediatric and family practices are using many recommended quality improvement strategies to some extent in their practices.
- Forty-one percent of responding practices were recognized as a medical home by a health care organization, most commonly (37%) by the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH).

- Most practices reported that they often use patient safety best practices (e.g. medication reconciliation) (74%), clinical practice guidelines and checklists in patient records (69%), patient registries to track individual patients with a particular disease or condition (62%) and measurement of patient/family satisfaction (52%). Less than a third of reporting practices used learning collaboratives, benchmarking performance with other practices, health literacy communication strategies, or rapid cycle improvement models a great deal.
- More than three-quarters of the practices remind patients about upcoming appointments (86%), document preventive services and risk screenings in charts or electronic health records (78%), and track referrals (72%). Most of the practices also indicated that they always: check immunizations at all visits (69%), use a developmental screening tool at ages one, two, and three years of age (59%), and test children insured by MaineCare for lead at one and two years of age (56%).
- There are still opportunities for improvement. Fewer than half of the practices always identify and contact patients who are behind for tests or care (45%), administer lead screening questionnaire for children at ages 1 and 2, or test children insured by MaineCare for anemia between ages 9 and 15 months (44%). Fewer than one-quarter of the practices reported that they always conduct pre-visit planning (24%) or use an autism-specific screening tool between 16 and 30 months (23%).

Data Systems Used to Track and Monitor Care

- While many practices indicated they use registries to track immunizations (58%) and children with asthma (44%), less than one-quarter used them to track overweight children, childhood diabetes, lead screening or testing. In addition, less than 5% tracked Attention Deficit/Hyperactivity Disorder (ADHD), developmental delays, autism, or other special health care needs.
- Nearly all responding practices (94%) reported using ImmPact, the state's population-based immunization registry and information system.
- ImmPact allows health care providers to record immunizations, validate immunization history, produce recall and reminder notices, vaccine usage and client reports, and manage vaccine inventory. Practices reported that they use ImmPact most often to enter patient immunization data (97%), review patient up-to-date rates (92%), and manage per-dose immunization inventory (92%). Many also use ImmPact to generate immunization coverage reports for the practice as a whole (84%) and aggregate immunization inventory management (83%). Less than half (45%) reported that they use ImmPact to generate reminders for patients that are due or overdue for immunizations. Over half (51%) of the practices reported an interest in learning more about how to use specific ImmPact features.

Use of Electronic Health Records for Quality Improvement

- The majority of pediatric and family practices (78%) indicated that they had a fully installed electronic health record (EHR) in their practice. This rate of EHR adoption is higher than previously reported by pediatric and family practices in a prior state survey about health information technology, suggesting that EHR installation has continued to grow.
- Over 90 percent of the practices that had EHRs reported using them to access patient notes, medication

lists, and problem lists (99%); view test results (95%), and obtain information about potential patient medication interactions (91%).

- Far fewer (64%) reported using their EHRs to generate reminders for clinician follow-up or to display Bright Futures guidelines recommended by the American Academy of Pediatrics for well child visits (51%) or to document the provision of the Bright Futures Standard of Care (48%).

Awareness and Use of Financial Incentives and Data for Quality Improvement from Payers

Many health insurers and health plans in Maine, including MaineCare, provide data to practices about the quality of care provided to health plan members receiving care from that practice. Some payers also provide additional payment incentives to practices that perform above certain quality measures thresholds. For MaineCare, these incentives are available to eligible office-based practices through Maine's Primary Care Provider Incentive Program (PC-PIP). The survey asked about quality reports and financial incentives provided by payers and how practices use MaineCare reports and incentives for quality improvement.

- The vast majority of responding pediatric and family practices indicated they received data from MaineCare (84%) and commercial payers (81%) about the care provided to members served at their practice site.
- While nearly three-quarters of practices receiving MaineCare utilization review (UR) reports indicated they reviewed them, only half (56%) of respondents said their practice uses these reports to monitor quality for MaineCare patients, and 48% indicated that the MaineCare Utilization Review performance measures had little or no influence on their practice operations.
- Less than one-third of practices (31%) indicated that they had received a PC-PIP incentive from MaineCare. However, more than half (53%) of respondents did not know whether or not the practice had received PC-PIP incentive payments.
- Within practices that reported receiving MaineCare PC-PIP payments (N=33), the vast majority indicated they reviewed PC-PIP reports (82%). One third (33%) were very familiar and more than half (55%) were somewhat familiar with the specific PC-PIP performance measures.
- More than half (56%) of the practices indicated they had received financial incentives other than the MaineCare PC-PIP. More than two thirds of those receiving these other incentives indicated they were from commercial insurers (69%).
- MaineCare incentives may have more influence over practice operations than performance reports alone. For practices that reported receiving a PC-PIP payment, 58% indicated that the PC-PIP influenced their practice operations a great deal or moderately. In contrast, only 41% of practices that received UR reports, indicated it influenced their practice operations a great deal or moderately.
- Among practices receiving an incentive through the PC-PIP, well-child visits, receipt of Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and appropriate ER use measures were reported to have the most influence on practice operations. In general, most practices that received the PC-PIP were very (32%) or somewhat (42%) satisfied with the PCPIP.

- When asked about possible changes to the PC-PIP, practices were most supportive of aligning MaineCare incentives with Pathways to Excellence (PTE), the Maine Health Management Coalition's public reporting program (in which two-thirds of responding practices participated), rewarding primary care providers for implementing EHR systems, and providing information to facilitate practice follow up with MaineCare members about their care.

The results of this survey of pediatric and family practices provide a useful snapshot of child health quality improvement activities in Maine that will help inform IHOC's practice improvement efforts going forward. Findings will also help inform the design of a follow-up survey to be fielded in 2014, which will allow more detailed analyses of IHOC's impact over time on child health quality improvement statewide and within specific subgroups of practices.

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Introduction and Background

Introduction

This Chartbook is being produced as part of the local evaluation of the Improving Health Outcomes for Children (IHOC) project in Maine. The report is intended to provide baseline information about pediatric and family practices quality improvement data systems and activities based on a survey of practice managers conducted in the winter of 2011-12. The survey will be conducted again in Year 5 of the IHOC project to assess how quality improvement and data efforts changed statewide during the period of the IHOC project.

Background

In February 2010, Maine and Vermont were awarded a five-year demonstration grant from the Centers for Medicare and Medicaid Services (CMS) to improve the quality of care for children who are insured by Medicaid and the Children's Health Insurance Program (CHIP). In Maine, IHOC seeks to bring together public and private child health stakeholders to help health systems and the Office of MaineCare Services meet their child health quality improvement goals. IHOC also provides medical practices with nationally recognized tools to enhance their ability to provide evidence-based care and to help track their progress when implementing quality improvement. Ultimately, by developing a more streamlined, coordinated, and quality-based infrastructure, we anticipate earlier identification of special needs, improved health outcomes, and decreased costs.

Description of the Survey

Survey Development

The survey is intended to inform Maine's Improving Health Outcomes for Children (IHOC) initiative and measure how pediatric and family practices use office systems and clinical or other data to inform quality improvement efforts. The survey is part of IHOC's local evaluation to assess the statewide impact of standardizing measures, expanding HIT for data collection, and building medical homes through pediatric-focused learning sessions. The survey was designed to answer the following key questions:

- To what extent are Maine's child health providers aware of and using data for quality improvement in their practices?
- How do pediatric quality measures and incentives influence practice change and quality improvement?
- How prepared are Maine's child health providers to use enhanced HIT systems?
- Are MaineCare reports meaningful to providers, are there barriers to their use and how could reporting of measures be improved?

The evaluation team used these broad evaluation questions to develop and select specific survey items. To the extent possible, the evaluation team attempted to use questions from existing surveys based on literature review of practice quality surveys including those developed by the American Academy of Pediatrics. We also consulted with key stakeholders including IHOC physician consultants; medical directors and consultants at Maine DHHS; the Maine Chapter of the American Association of Pediatrics; and program managers responsible for administering program areas included in the survey, e.g. the Blood Lead Program of the Health and Environmental Testing Laboratory, and the Maine Immunization Program (both at the Maine Center for Disease Control and Prevention).

The survey also included several items about the responding practices including their medical home recognition status. A subset of these items was defined by the CHIPRA National Evaluation Team as part of the national evaluation. A copy of the survey instrument is available upon request.

Sample Development

The sample was drawn from MaineCare's database of all primary care practices participating in Primary Care Case Management that served children insured by MaineCare as of December 2009 (N= 340). We used a stratified sampling frame to oversample practices serving children participating in Maine's Patient Centered Medical Home pilot program (N=21) or in the IHOC First STEPS learning initiative (N=15), other pediatric (N=25) and family practices (N=107) that serve a high volume of MaineCare children.

Survey Administration

The survey was administered by the Muskie School's Survey Research Center (SRC) using Snap®, a survey software program. The survey itself was web-based. As an incentive, respondents completing the survey were entered into a drawing to win one of three iPad 2®s.

An initial recruitment letter was sent to each practice site to 1) describe the purpose of the survey, 2) identify or verify the identification of the site's Practice Manager, and 3) obtain the email address for the Practice Manager. In addition, staff phoned each practice where either the Practice Manager's identification or e-mail address was unknown and requested this information. The survey was launched in November 2011 when SRC staff e-mailed information about the survey and an individual survey link to each practice site. SRC staff also e-mailed reminders containing the survey link several times during the following eight weeks. SRC staff conducted follow-up phone calls to all non-respondents to encourage them to complete the survey. Because the initial response rate was lower than desired, this continued for an eight week period.

Response Rate

The response rate was 64% or 108 of 168 practice sites that had been invited to participate. We initially received 113 surveys. We excluded three from our analysis because they did not meet our threshold for completion, and one survey each from the two practice sites that had submitted two surveys.

Data Analysis and Presentation

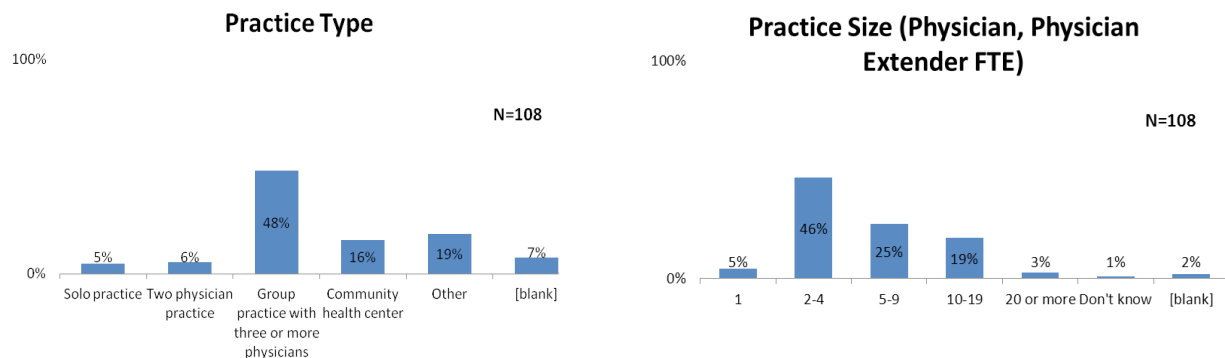
The Survey responses were downloaded from Snap® and analyzed using Microsoft Access® and SAS® Version 9.2. The information contained in this Chartbook was collected in November 2011 through April 2012 and provides a baseline for that period. The charts present overall frequencies for the survey questions. We also present selected cross-tabulations by several practice characteristics, for example practice specialty and practice size. The discussion of the cross-tabulations is highlighted. Tests for statistical significance will be conducted in the final report comparing Year 5 survey data to the baseline data contained in this Chartbook.

Responding Practice Characteristics

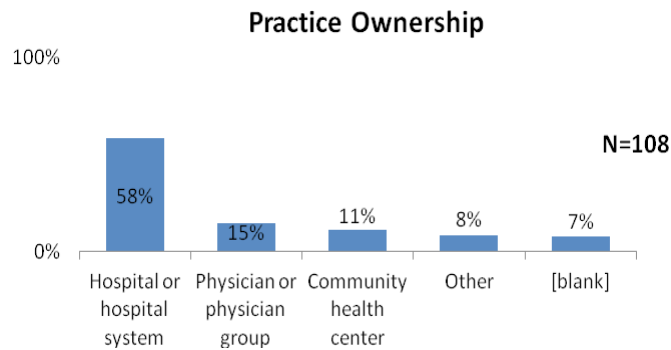
Practice Size and Ownership

The majority of responding practices were small to medium-sized practices based on the number of full-time equivalents (FTEs). Approximately half (51%) of responding practice sites reported having less than five FTE providers (including physicians and physician extenders). A quarter (25%) reported having five to nine FTE providers, and 22% had ten or more FTE providers.

Almost half of the responding practices reported that they were group practices with three or more physicians, 16% were community health centers, and 11% were in solo or two-physician practices. Nineteen percent of the practices selected “other” as the practice type. “Other” practices included federally qualified health centers, rural health centers, and residencies. About 7% of the respondents did not select a response.

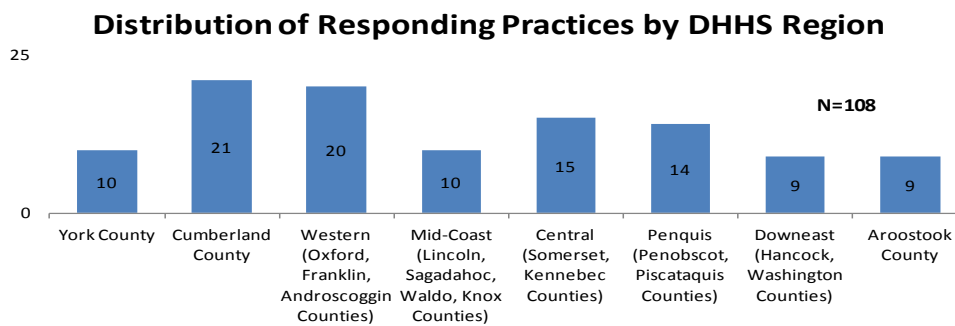


Most (58%) of the practice sites responding to the survey were owned by a hospital or hospital system. A much smaller proportion of the responding sites were physician or physician group-owned practices. Just over ten percent (11%) were community health centers. Fifteen percent of the practices did not answer the question or indicated that the practice site was owned by some other entity. Family practices were more likely (61%) to be owned by a hospital or hospital system than pediatric practices (50%). Pediatric practices were more likely (29%) than family practices (10%) to report being owned by a physician or physician group practice (data not shown).

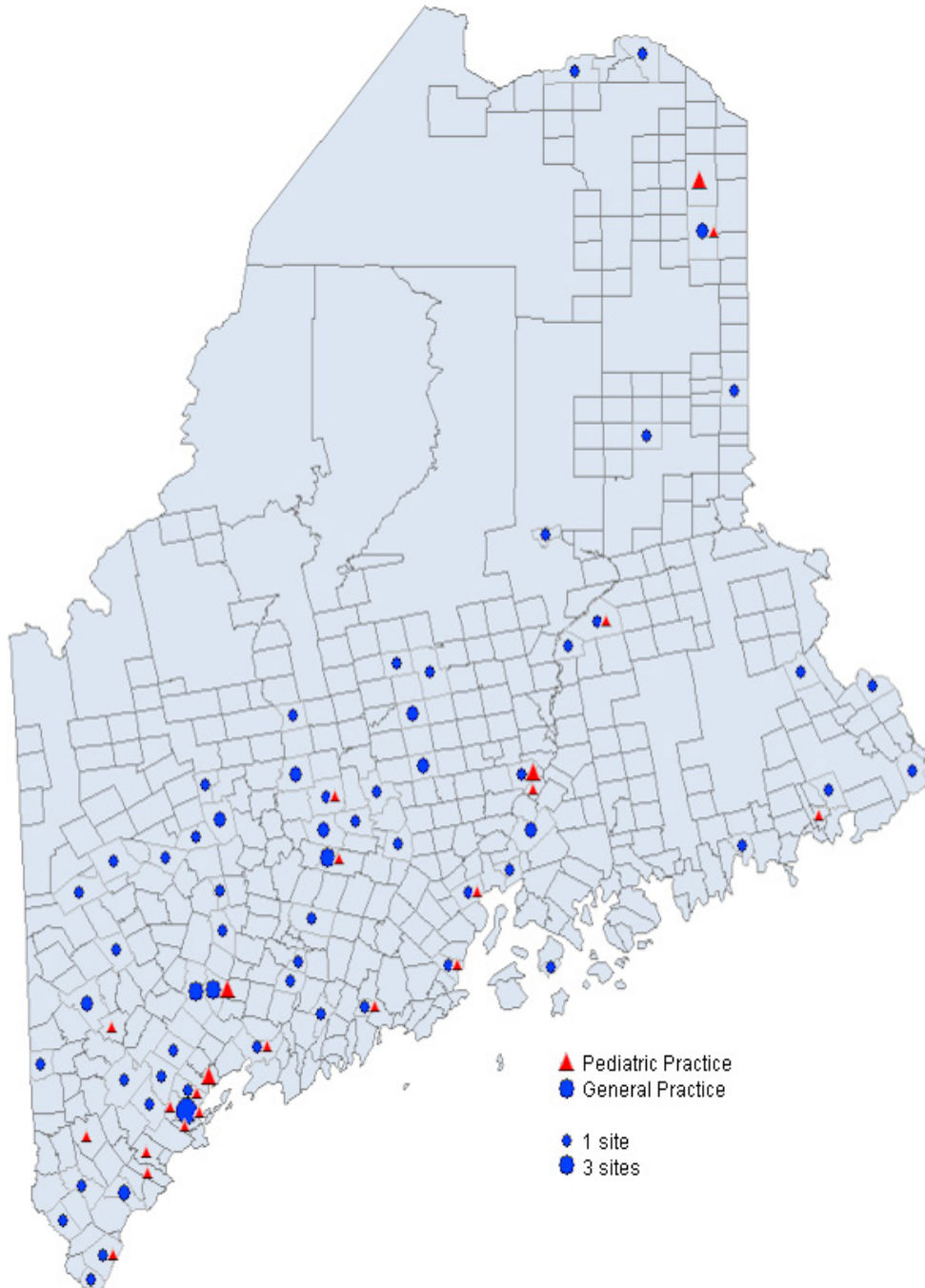


Geographic Location

Responding practices were located in all DHHS regions, with more practices participating from the more populous regions. The chart and map below depict the geographic distribution of responding practice sites.



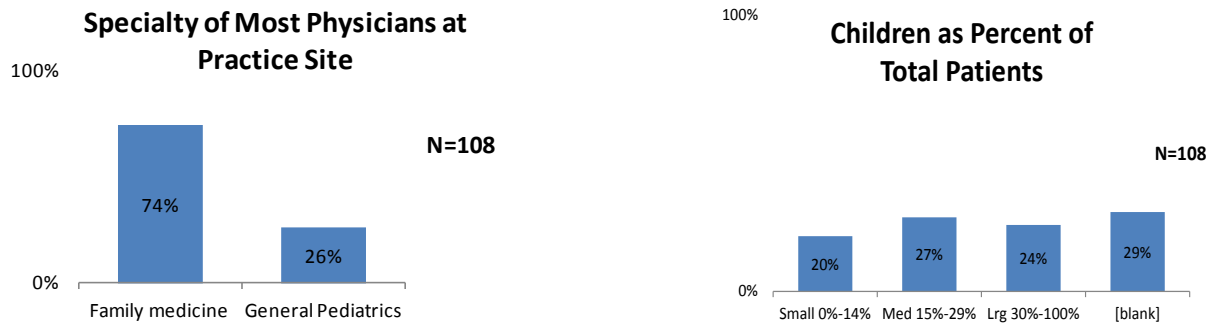
GEOGRAPHIC DISTRIBUTION OF RESPONDING PRACTICES (N=108)



Practice Specialty and Patient Panels

Seventy-four percent of the responding practices indicated that the specialty of most of the physicians at the practice sites is family practice. Twenty-six percent of the responding practices indicated that most physicians at the practice site are pediatricians. Based on an estimated 43 pediatric and 296 family practices in the PCCM program,¹ survey respondents represent nearly two thirds of all pediatric practices (65%) and more than one-quarter of family practices in the state (27%).

We asked practices to estimate the proportion of children and adolescents (age 0-21) in their total patient panel. While 29% of the respondents did not answer the question, nearly one-quarter of responding practices (24%) indicated that children and adolescents represented 30% or more of their panels. Twenty-seven percent of the responding practices had between 15 and 30% of children and adolescents in their panel. Nineteen percent of responding practices had less than 15% of children and adolescents in their panels.



Similarly, practices that responded to the survey varied in the proportion of MaineCare children in their panels, ranging from those that MaineCare represented less than 30% of children served to those where they represented more than 60% of children on their panel. While a third of the responding practices either did not answer the question or provided an invalid response, 18% of the practice sites served a small proportion of MaineCare children (less than 30%), 23% reported a medium proportion of MaineCare children, and 27% reported a high proportion of patients, ages 0-21, insured by MaineCare.

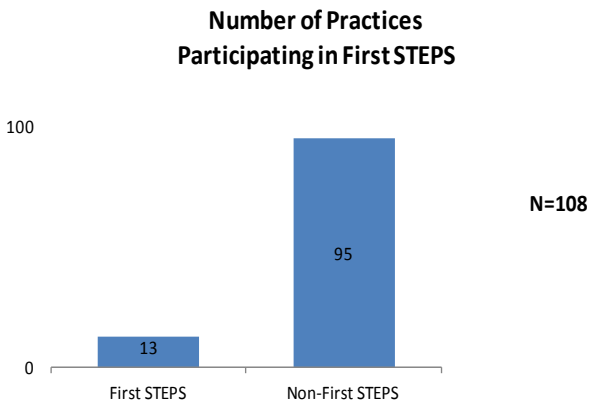
A large majority, 83%, indicated that they accept all MaineCare patients, 8% indicated that they care for existing MaineCare patients but do not accept new MaineCare patients, and one practice reported accepting MaineCare patients up to a certain percentage of the patient panel.

We also used administrative data from MaineCare to estimate the number of MaineCare children served by responding practices. Based on Primary Care Case Management (PCCM) data in December 2009, responding prac-

¹ Based on MaineCare Utilization Reports for December 2009.

tices served an estimated 67,372 MaineCare children (34,656 in the pediatric and 32,716 in the family practices)². This represents more than 57% of the total number of MaineCare children served by the PCCM program in that year.

As part of Maine's IHOC initiative, 22 pediatric and family practices, most of whom serve a high-volume of MaineCare children, are participating in the First STEPS learning collaborative to improve preventive health screening. Thirteen practices, nearly 60% of the IHOC practices responded to our survey (see below).



Medical Home Recognition

Forty-one percent of the responding practice sites reported that they were recognized as a medical home by a health care organization. The Patient-Centered Medical Home (PCMH) is a health care delivery model that seeks to coordinate patient care in a primary care setting. Thirty-seven percent of the practices reported that their practice site is recognized by the National Committee for Quality Assurance (NCQA) as a PCMH (18% were in the process and 25% were planning to apply for NCQA PCMH certification). Family practices participating in the survey appear to be more likely (40%) than pediatric practices (29%)

² This estimate does not include the children at two practice sites that responded to the survey.

A Comparison of First STEPS Respondents to Other Respondents

This section presents a brief summary of how First STEPS practices compare to the other practices that responded to the survey at baseline. The survey is intended in part to measure change in quality improvement over time in these practices relative to other practices in the state.

In general, First STEPS practices were similar to other responding practices at baseline in terms of practice characteristics, although more First STEPS practices are pediatric practices than other responding practices (69 v. 20%).

Practice Level Quality Improvement

In terms of quality improvement, First STEPS (FS) practices appear to be fairly similar in their reliance on many quality improvement process and tools (patient safety best practices, clinical practice guidelines, checklists/flowcharts in patient records, patient lists or registries for certain clinical conditions, patient satisfaction measurement, pay for performance incentives, learning collaborative, benchmarking, and health literacy strategies). However, First STEPS practices appear to be more likely to report that they rely on rapid cycle improvement models such as plan do study act (PDSA) to test and implement changes. 93% v. 61% reported that they rely on these models a great deal or moderately.

Data Systems Used to Track and Monitor Care

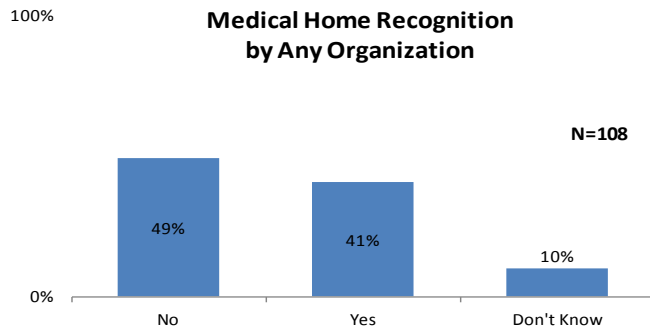
Compared with other practices, practices that participated in First STEPS appear to use many of the same data systems to track and monitor care. However, FS practices were more likely at baseline to have and use an automated registry for asthma; and they were more likely to set practice-level targets for asthma treatment, hearing screening, and autism screening. Furthermore while the groups appear fairly similar in their use of ImmPact components, FS practices were less likely to report using the aggregate immunization inventory management component of ImmPact.

First STEPS were largely similar to other practices at baseline in their use of quality improvement tools and in performing recommended standards of care (reminding patients of appointments, documenting preventive care delivered, tracking referrals, using developmental screening, lead screening and anemia screening). However, FS practices were less likely to systematically check immunizations at all visits (all the time 31% v. 74%, all or most of the time 77 v. 96%) and were less likely to identify and contact patients who are behind for preventive services (all the time 15 v. 49%, all and most the time 69 v. 77%); and more likely to use an autism specific screen at 16-30 months (all the time 46 v. 20%, all or most the time 46 v. 32%) and to have been trained in using PDSAs (46 v. 24%).

FS practices were also similar at baseline in their familiarity and review of MaineCare UR reports, but were less likely to report using the reports for quality improvement than other practices (22 v. 60%).

to be recognized by NCQA as a PCMH.

Fifty-five percent of the practices with NCQA recognition reported that they had been recognized at level three, 8% reported being recognized at level two, and 25% reported being recognized at level one. Recognition levels reflect how extensively practices meet requirements with level one indicating the most extensive level.



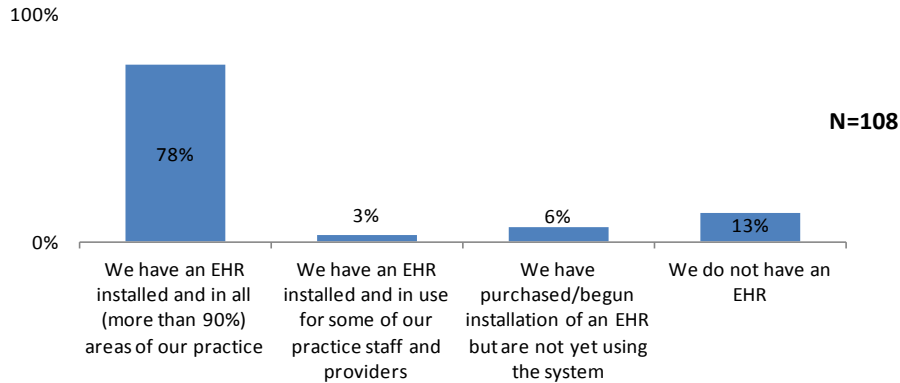
Smaller and medium-sized practices were less likely than large practice sites to indicate that their practice had been recognized as a medical home by any organization. Forty-eight percent of large, compared to 42% of medium and 38% of small practices indicated reported having been recognized as a medical home. Family practices appear to be more likely than pediatric practices to be recognized by any organization as a medical home (44% versus 32%).

Practices reported having used several different tools to assess the extent to which the practice met medical home criteria. Practices may use more than one organization's criteria. Almost half (46%) of the practices reported having used the Joint Commission's Primary Care Home Designation standards, 31% used TransformMED (a subsidiary of the American Association of Family Practices Medical Home Implementation Quotient), 23% used the Center for Medical Home Improvement's Medical Home Index, 8% used the Utilization Review Accreditation Committee standards and 8% used an insurer(s) medical home criteria. Fifteen percent reported using another organization's criteria.

Electronic Health Record Installed

More than three-quarters (78%) of the practices reported that they have an Electronic Health Record (EHR) installed in all (more than 90%) areas of their practice. Only 13% of the practices reported that they do not have an EHR. Nine percent of the practices were in the process of purchasing or installing an EHR. These figures indicate an increase in the number of pediatric and family practices with installed EHRs since 2010, the date of a previous statewide HIT survey. Survey responses show the most common EHR systems among respondents is GE Healthcare Centricity (32%), eClinicalWorks (13%), Epic Systems, and NextGen (11%).

EHR Status among Pediatric and Family Practices

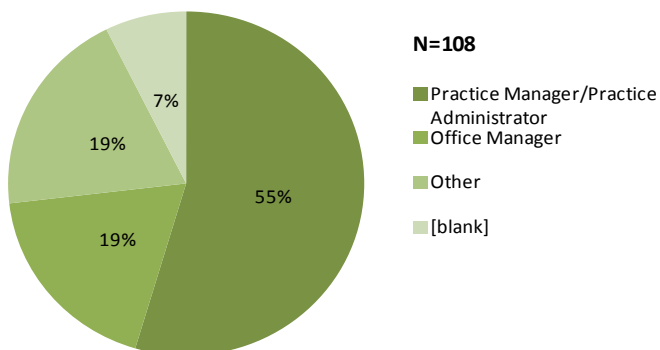


Large practices were more likely to report having a fully installed EHR. Ninety-one percent of the large practices reported have a fully installed EHR compared to 73% in small, and 78% in medium-sized practices.

Responder Role

Most of the respondents completing the survey indicated that they were either Practice Managers/Administrators or Office Managers. Over half (55%) were Practice Managers/Administrators and 19% were Office Managers. Another 19% selected the 'other' response and 7% did not provide an answer to this question.

Responder's Role in the Practice



Survey Results

Practice Level Quality Improvement

Office Systems and Processes for Quality Improvement

This section of the Chartbook presents baseline data about practice level quality improvement (QI) activities at Maine's pediatric and family practices including information obtained from respondents about the:

- tools and processes used at the practice sites, e.g. registries, electronic health records, target-setting, financial incentives
- tools used external to the practices, e.g. state immunization registry,
- practice organization, e.g. patient centered medical home (PCMH) designation, presence of clinical leadership, and
- use of child health quality data from external sources, e.g. insurers, accrediting organizations

Tools and Processes Used for Quality Improvement

The survey included a series of items about the extent to which the practices use certain quality improvement strategies to improve the quality of care among children in the practice. For each of the strategies listed, a majority (65% - 94%) of the practices indicated that they rely on these strategies a great deal or moderately to improve the quality of care of the children with the practice. Over half of the practices indicated that they rely on five of the QI practices a great deal: patient safety best practices (74%), clinical practice guidelines and checklists in patient records (69%), patient registries (62%) and measurement of patient/family satisfaction (52%).

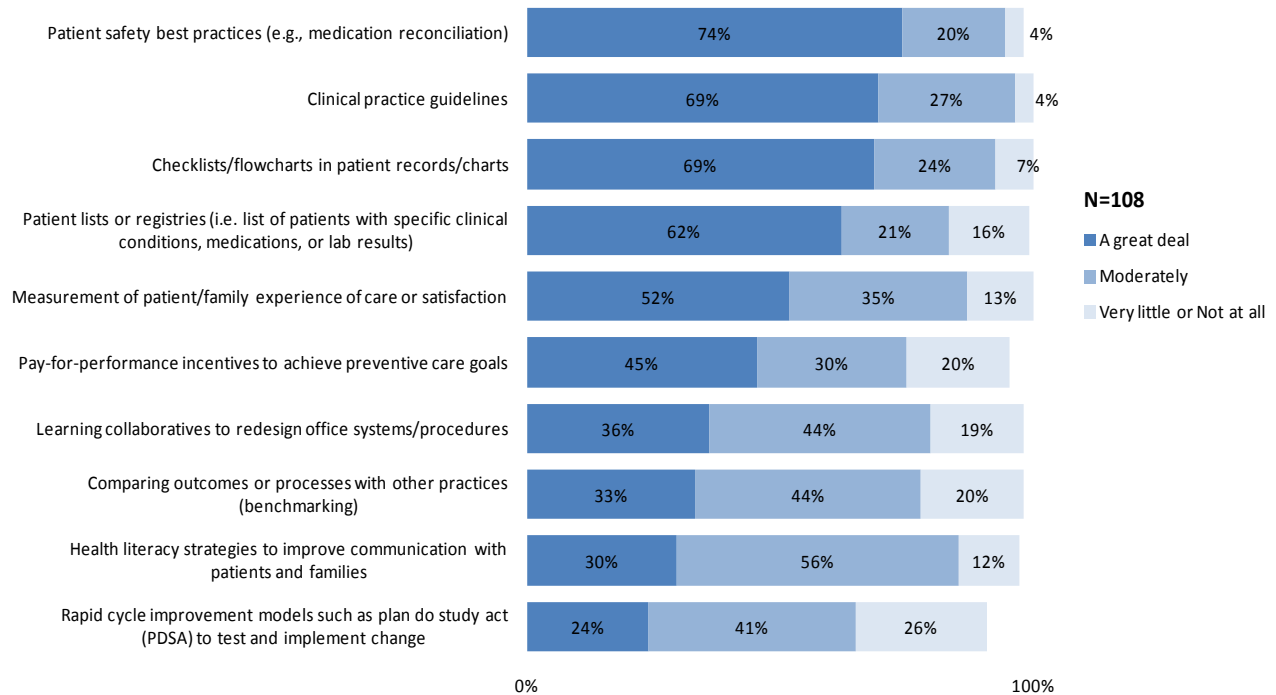


Differences by Practice Characteristics

A higher proportion of medium and large practices (as measured by the number of providers) reported relying on clinical practice guidelines and patient lists or registries than smaller practices. Eighty-one and 70% of the medium and large practices, respectively, reported relying on clinical practice guidelines a great deal for quality improvement for children; whereas 62% of small practices indicated relying on them a great deal. Seventy percent of medium and large practices use patient lists or registries a great deal for quality improvement for children in their practices, compared to only 55% of the smaller practices.

Family practices were more likely than pediatric practices to report that the practice relies a great deal on benchmarking and health literacy strategies. Eighty-two percent of the family practices indicated that they rely a great deal or moderately on benchmarking for quality improvement within the practice site. Family practices were also more likely to report that they use health literacy strategies for quality improvement. Thirty-four percent of the family practices, versus 18% of the pediatric practices, reported relying a great deal on these strategies (data not shown).

Extent of Use of Selected Quality Improvement Tools

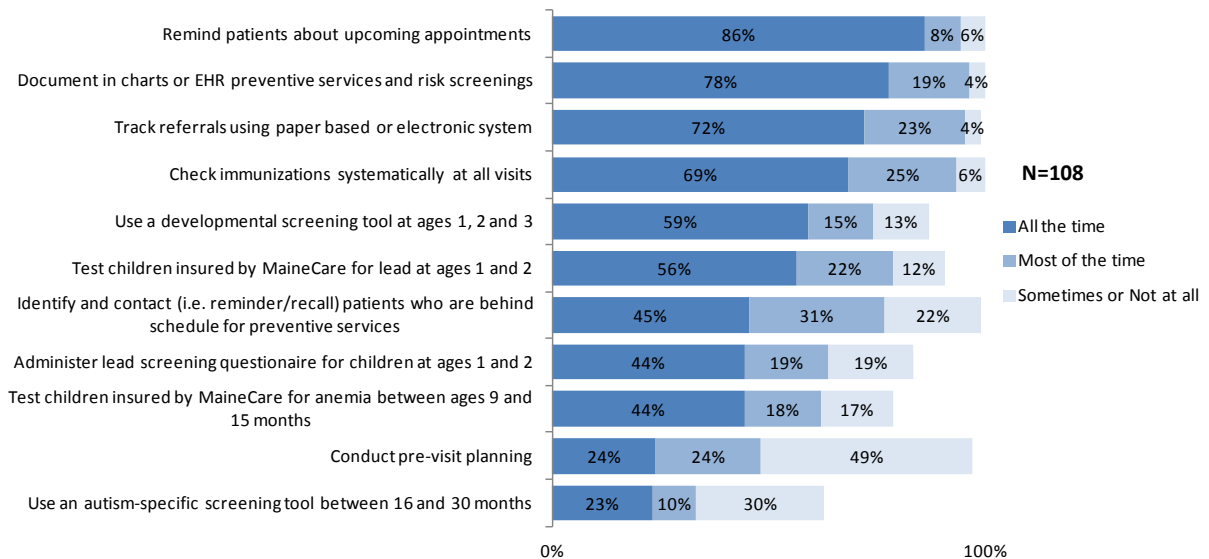


The survey also included an item about several best practices for quality improvement in delivering the standard of care. The quality improvement activities and standards of care were selected either because they appear in the quality improvement literature as a recommended practice or because they are required by the MaineCare program.

More than three-quarters of the practices remind patients about upcoming appointments (86%), document preventive services and risk screenings in charts or electronic health records (78%), and track referrals (72%). Most of the practices also indicated that they always: check immunizations at all visits (69%), use a developmental screening tool at ages one, two, and three years of age (59%) , test children insured by MaineCare for lead at ages one and two (56%).

Fewer than half of the practices always: identify and contact patients who are behind for tests or care (45%), administer lead screening questionnaire for children at ages 1 and 2 and test children insured by MaineCare for anemia between ages nine and 15 months (44%). Fewer than one-quarter of the practice reported that they always conduct pre-visit planning (24%) and use an autism-specific screening tool between 16 and 30 months (23%).

Frequency of Performing Selected QI Activities and Standards of Care



Differences by Practice Characteristics

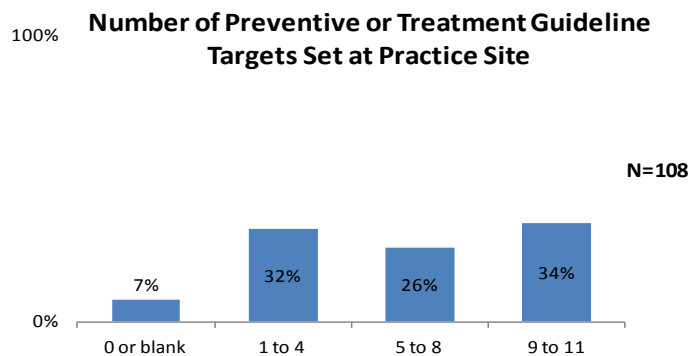
We found some variation, by practice size, in frequency of performing selected quality improvement activities and standards of care. For example, medium-sized practices were less likely to report performing certain QI practices either all the time or most of the time. This was the case for checking immunizations systematically at every visit, identifying and contacting patients lagging in preventive services, and conducting pre-visit planning. Medium-sized practices were more likely to report administering lead screening questionnaires for children at ages one and two and using developmental screening tools at ages one, two, and three. However, medium and small practices were more likely to report testing children insured by MaineCare for anemia between ages nine and 15 months. Seventy-one percent of medium and 62% of small practices reported conducting these tests all or most of the time, compared to 56% of large practices.

By specialty, family practices were more likely to report performing certain tests and screenings all of the time than pediatric practices. For example, family practice were more likely to report administering a lead screening questionnaire for children at age one and two (57 versus 40%) and using a developmental screening tool at ages one, two, and three (66 versus 56%). Also, family practices were more likely to indicate that their practice site tests children insured by MaineCare for lead at ages one and two (71 versus 51%) and tests children insured by MaineCare for anemia between ages nine and 15 months (71 versus 25%).

Practice-Level Targets to Meet Guidelines

Setting practice-level targets for meeting guidelines for preventive care or treatment is an accepted practice for improving practice performance on targeted guidelines. Nearly all of the practice sites (92%) set targets for preventive care or treatment. About one-third (34%) of the practices set targets for meeting nine to 11 preventive care or treatment guidelines. Twenty-six percent of the practice sites set targets for five to eight guidelines and 32% set one to four such targets.

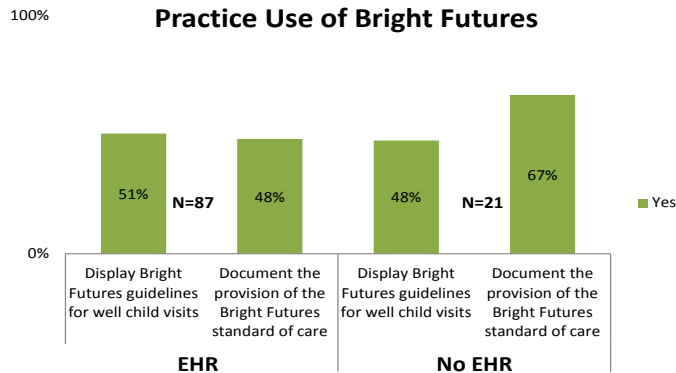
Pediatric practices were more likely to report setting nine to 11 targets for preventive or treatment guidelines whereas family practices were more likely to report setting between one and four of such targets.



Practice Level Processes Related to the Bright Futures Standard of Care

The survey included items related to Bright Futures. Bright Futures was developed by the American Academy of Pediatrics (AAP) as a standard of care that may be used to implement the federally-mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children and adolescents. MaineCare (Maine's Medicaid program) uses the Bright Futures standard of care for this purpose.

About half of the responding practices reported that they display Bright Futures guidelines for well child visits. Practices with electronic health records (EHRs) were just about as likely to report displaying the guidelines as practices with no EHR (51% and 49%). Interestingly, practices without EHRs were more likely to report that they document the provision of the Bright Futures standard of care than practices with EHRs (69% and 48%).



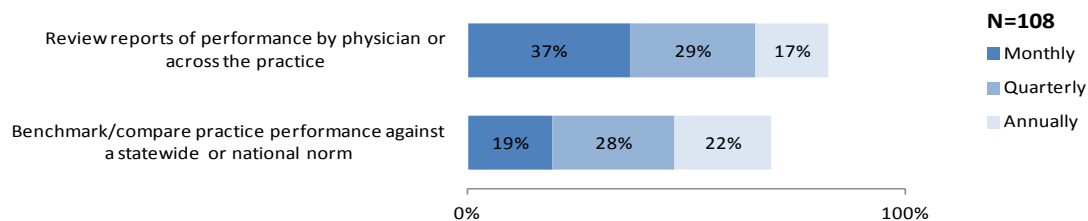
Differences by Practice Characteristics

Of the practices with EHRs, small practices were more likely to report that they display Bright Futures guidelines for well-child visits (60% compared to 43% in medium and 48% in large practices) and document the provision of the Bright Futures standard of care (55% in small, versus 48% in medium and 43% in larger practices).

Provider and Practice Benchmarking

Performance reviews and benchmarking are additional means of improving quality at the practice level. Sixty-six percent of the practice sites reported reviewing performance by physician or across the practice site monthly or quarterly. Forty-seven percent of the practices benchmark or compare practice performance against a state- or nation-wide norm.

Frequency of Physician Provider and Practice Performance Benchmarking





Differences by Practice Characteristics

Thirteen percent of the small practices reported that they do not conduct physician/practice performance reviews, compared to only 4% of large practices, and none in medium practices. A smaller proportion of small practices reported conducting reviews either on a monthly or quarterly basis, whereas 78% of medium practices and 74% of large practice reported doing so.

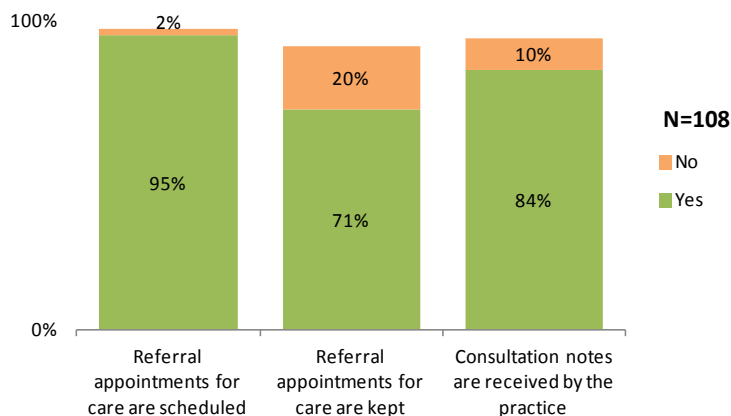
Smaller practices were also less likely to report benchmarking their practice sites against statewide or national norms. Twenty percent of small practices, 15% of medium and 9% of large practices reported making these comparisons. A somewhat larger proportion of medium-sized practices (52%), versus 44% of large practices and 49% of small practices benchmark practice performance against statewide or national norms on a monthly or quarterly basis.

Pediatric Specialty Referrals

The survey included several items relating to pediatric specialty referrals. This series of questions was developed to learn about whether practice sites have mechanisms in place to assure that 1) referral appointments for care are scheduled, 2) consultation notes are received by the practice, and 3) referral appointments are kept.

Nearly all (95%) of practices indicated that they had a mechanism in place to assure that referral appointments are scheduled. Nearly three-quarters (71%) indicated that they have a process in place to assure that these appointments are kept. A large majority (84%) indicated that they have process in place to assure that consultation notes from specialty provider referrals are received by the practice.

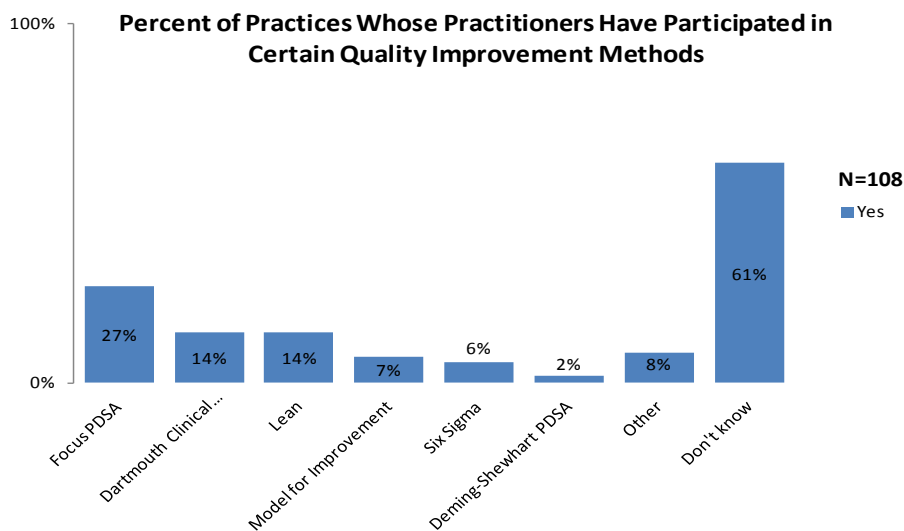
Percent of Practices with Specialty Referral Processes in Place



Practitioners' Participation in Quality Improvement Training Methods

The survey included an item about whether providers at practice sites had had training in selected quality improvement models and frameworks. Sixty-one percent of the respondents indicated that they did not know whether providers at the practice sites had had training in the methods and frameworks listed. This suggests that other practice personnel, such as clinical leaders, might have been more likely to have the information necessary to answer this question.

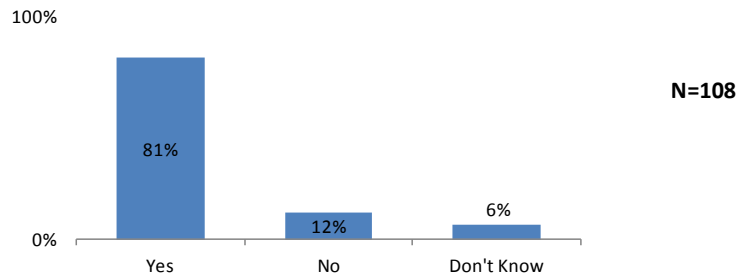
Twenty-seven percent of the practices indicated that providers at the practice location had had training in Focus PDSA (plan, do, study, act). Fourteen percent reported that practitioners had had training in Dartmouth Clinical Microsystems and Lean. Seven percent of the respondents indicated that practitioners had had training in Model for Improvement and 6% reported that practitioners had had training in Six Sigma. Two percent said that practitioners had participated in Deming-Shewhart PDSA. Because this was a 'check all that apply' question, the same practice sites may be represented in numerous of the response options.



Community Resources for Parents

The vast majority of practice sites (81%) reported that they maintain an up-to-date list of community resources for parents. Just 12% of the practices indicated that they do not maintain an up-to-date list of community resources.

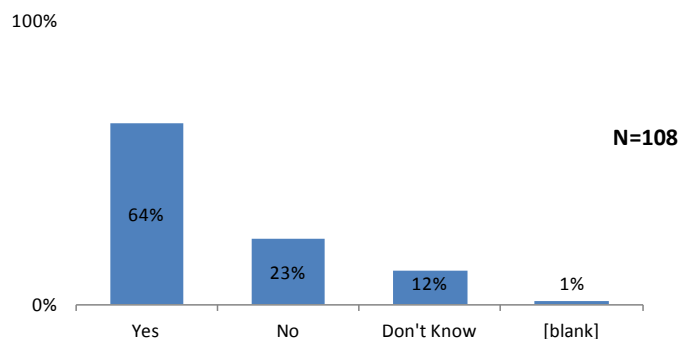
Practices Maintaining an Up-to-Date List of Community Resources for Parents



Public Reporting

Sixty-four percent of the responding practices reported participation in Pathways to Excellence (PTE), a public reporting initiative of the Maine Health Management Coalition (MHMC). MHMC is an employer-led health care improvement initiative that measures and publicly reports quality data on primary care practices.

Practice Participation in Pathways to Excellence



Data Systems Used to Track and Monitor Care

Registries

A registry is an organized system:

- to collect, store, analyze, and disseminate information on individual patients who have a particular disease

or condition (for example diabetes) as well as

- to generate reports for quality improvement among broader groups such as for patients of one practice, for a health system, or patients of one particular provider within a practice.

Conditions/Screens Tracked with Automated Registry

The survey included a question about the conditions/screens (for example screening for risk of lead exposure or developmental delays) for which practice sites have and use an automated registry. Responding practices most frequently indicated that they had and used a registry for immunizations, 58%; asthma, 44%; Body Mass Index (BMI), 23%; and childhood diabetes, 20% (see below).

Condition/ Screening	Practices (%) N=108
Immunizations	58
Asthma	44
BMI Greater than 85%	23
Childhood Diabetes	20
Lead Screening	14
Lead Testing	11
Attention Deficit/Hyperactivity Disorder (ADHD)	4
Children with Special Health Care Needs	3
Developmental Delay	3
Autism	2
Other	7



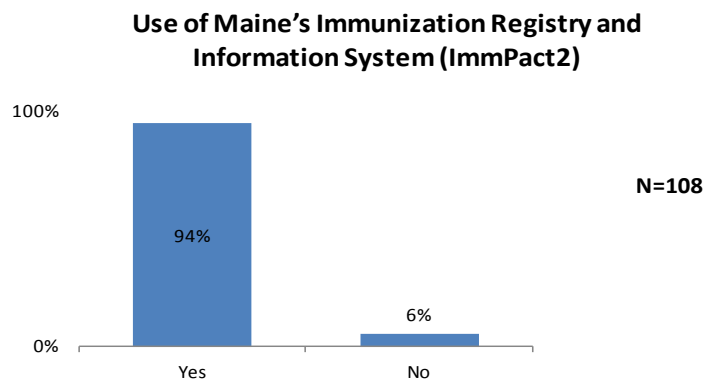
Differences by Practice Characteristics

Medium size (as measured by number of providers) practices were more likely than small or large practices, to report having and using an automated registry for a number of conditions/screens (asthma, body mass index of greater than 85%, immunizations, childhood diabetes, lead screening, lead testing). Twenty-two percent of the small and large responding practices indicated they had no registry.

Pediatric practices were more likely (43%) than family practices (24%) to report having and using automated registries for three or more conditions. Family practices were more likely (48%) than pediatric practices (36%) to report having and using one to two automated registries. Pediatric practices were more likely than family practices to have and use automated registries for asthma and body mass index greater than 85%, whereas family practices were more likely (24%) than pediatric practices (11%) to have and use an automated registry for childhood diabetes.

Use of State Immunization Registry

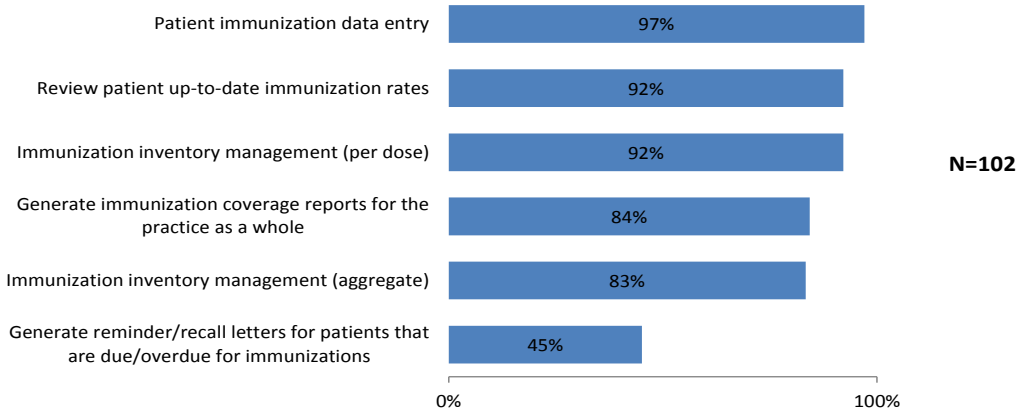
Nearly all responding practices (94%) reported that they use the State of Maine immunization registry and information system, ImmPact. ImmPact is a population-based Web application containing consolidated demographic and immunization history information. ImmPact is able to perform a variety of functions for health care providers, including: recording immunizations, contraindications, and reactions; validating immunization history and providing immunization recommendations; producing recall and reminder notices, vaccine usage and client reports, and Clinic Assessment Software Application (CASA) extracts; and managing vaccine inventory.



Large majorities of the responding practice sites indicated that they use ImmPact's features. Nearly all of the practices reported using ImmPact to enter patient immunization data (97%), to review patient up-to-date rates (92%), and to manage per-dose immunization inventory (92%). Large majorities of the practice sites also reported using ImmPact to generate immunization converge reports for the practice as a whole (84%) and aggregate immunization inventory management (83%). Nearly half of the practices (45%) reported that they use ImmPact to generate reminders for patients who are due or overdue for immunizations.

While many practices reported that they use particular ImmPact features, over half (51%) of the practices reported an interest in learning how to use ImmPact features.

Percent of Practices Reporting Use of ImmPact Features.



Differences by Practice Characteristics

A greater proportion of small practices (88%) reported using ImmPact's immunization inventory management than large practices (78%).

Quality Improvement and Electronic Health Records

The survey included several items about practice use of EHRs to perform certain well child visit functions. The items were selected because the functions are considered to be generally accepted standards of care for a well child visit.

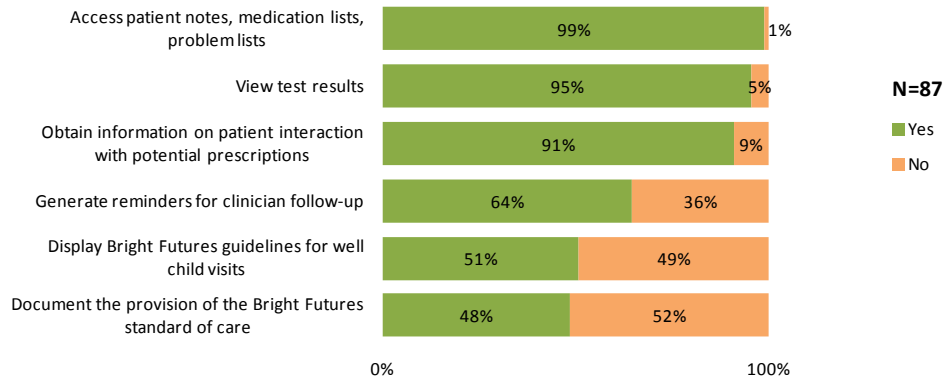
More than 90 percent of the practices reported using their EHRs to:

- access patient notes, medication lists, and problem lists (99%),
- view test results (95%), and
- obtain information about potential patient medication interactions (91%).

Sixty-four percent of the practice sites reported that they used their EHRs to generate reminders for clinician follow-up.

As was reported earlier in this report, about half of the practices indicated that they use their EHRs to display Bright Futures guidelines for well child visits and to document the provision of the Bright Futures Standard of Care.

Practice Use of EHR in Well Child Visit



Financial Incentives for Quality Improvement

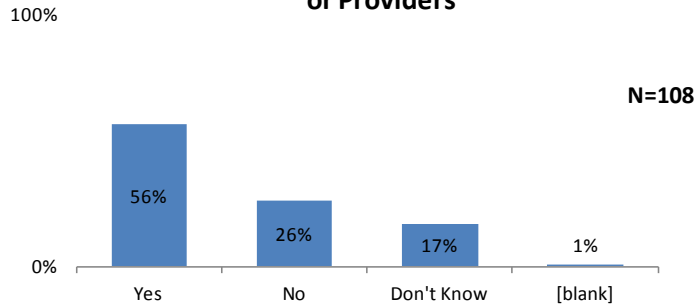
Financial incentives can be used to reward demonstrated performance in clinical practices against quality criteria such as standards of care. Under incentive programs, physicians who meet criteria receive enhanced compensation. The survey asked several questions about financial incentives at the practice sites. Fifty-six percent of the practice sites reported that the practice or providers at the practice receive financial incentives other than from MaineCare's Primary Care Provider Incentive. Sixty-nine percent of the responding practices reported that they receive incentives from commercial insurers. A much smaller proportion, 39%, receives incentives from their health system or physician hospital organization (PHO). Just over a quarter of the responding practices indicated that they receive incentives from MaineCare for meeting CMS meaningful use criteria associated with the use of the practice's EHR.



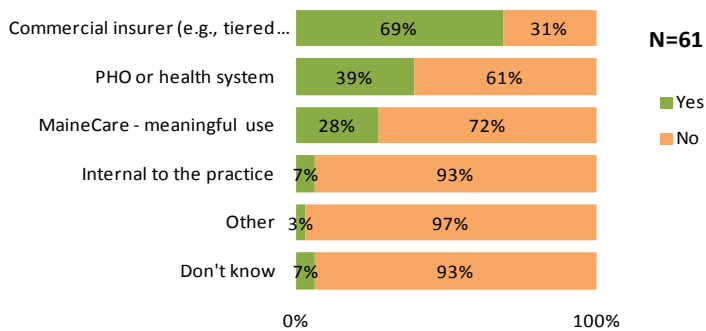
Differences by Practice Characteristics

Family practices appear to be more likely to report that they use the EHR to: generate reminders for clinician follow-up (68% in family practices as compared to 52% in pediatric practices) and to display Bright Futures guidelines for well child visits (55% in family practices as compared to 38% in pediatric practices).

Receipt of Financial Incentives for the Practice or Providers



Source of Financial Incentives for the Practice or Providers

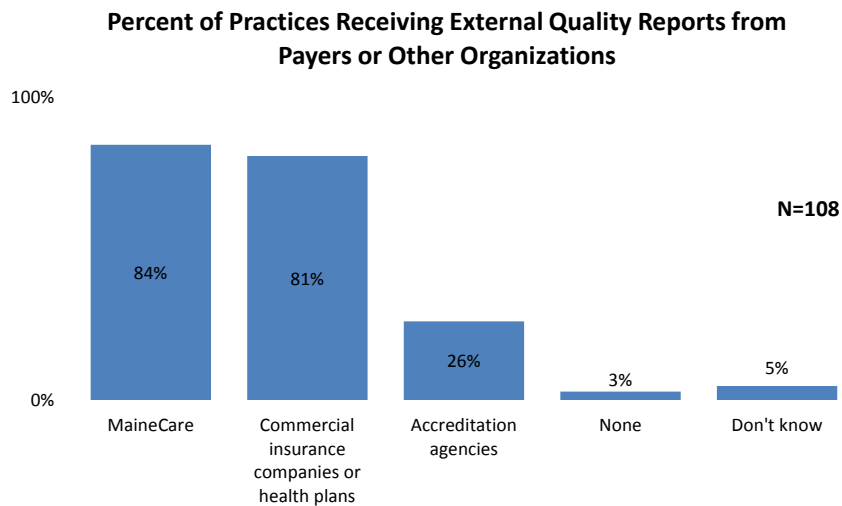


Practice's Awareness and Use of Data for Quality Improvement from Payers and Other Sources

Many health insurers and health plans in Maine, including MaineCare, provide data to practices about the quality of care provided to health plan members receiving care from that practice. Data provided and quality measures included in these reports vary by health plan. Some payers also provide additional payment incentives to practices that perform above certain thresholds on specific quality measures.

Sources of Quality Reports to Practices

The vast majority of responding pediatric and family practices indicated they received data from commercial payers (84%) and MaineCare (81%) about the care provided to members served at their practice site.

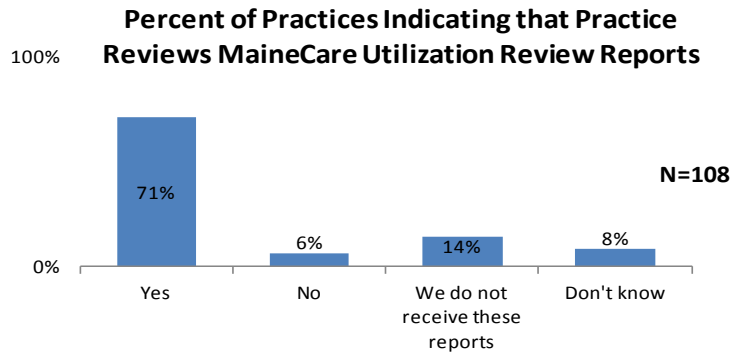


MaineCare Utilization Review Reports

As part of MaineCare's Primary Care Case Management (PCCM) program, participating primary care providers are sent utilization review reports (UR reports) biannually that summarize the utilization, costs and quality of care provided to MaineCare members in the practice's panel compared to other providers. These reports are generated from MaineCare claims and are intended to provide comparative performance information to practices for quality improvement and to serve as an educational tool for physicians. Practices are expected to review these reports and advise the Office of MaineCare Services of any errors. (MaineCare benefits manual (Ch 6, Sec 1)

Familiarity and Use of MaineCare UR Reports

The vast majority of pediatric and family practices (71%) indicated that they review MaineCare PCCM UR reports when they are sent to their practice; only 6% indicated they do not review UR reports. Although all practices in the survey sample were in the PCCM program as of December 2009, 14% of respondents indicated they did not receive UR reports and 8% did not know if their practice reviewed them.



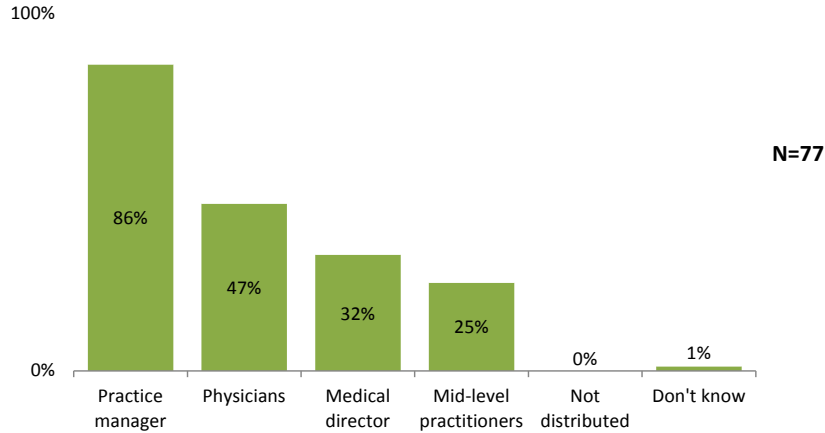
Differences by Practice Characteristics

Small practices were more likely to report that the practice site reviews the PCCM UR reports. Seventy-six percent of small, compared to 70% of medium and 57% of large practices reported reviewing these reports. Small and medium-sized practices were also more likely to report that physicians review UR reports. Fifty percent of small and 53% of medium practices, compared to 23% of large practices reported physician review of UR reports. Furthermore, small practices were more likely to report that MaineCare UR performance measures influence practice operations a great deal or moderately (50%) than at medium (30%) and large practices (27%).

Eighty-two percent of the responding family practices, versus 68% of the pediatric practices reported that they review the MaineCare UR reports. Additionally, respondents at family practices were more likely to indicate that physicians at the practice review the UR reports (50%) than at pediatric practices (39%).

Practice managers were cited most frequently as reviewing UR reports (86%) for the practice. Nearly half of the practices indicated that physicians review the reports (47%), and less than a third said that the medical director (32%) or mid-level practitioners (25%) reviewed them.

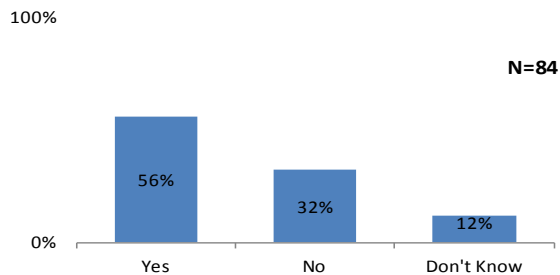
Practice Personnel Reviewing MaineCare Utilization Reports



*Percentages do not add to 100% because more than one staff or clinician may review UR reports within a practice; respondents were asked to check all that applied.

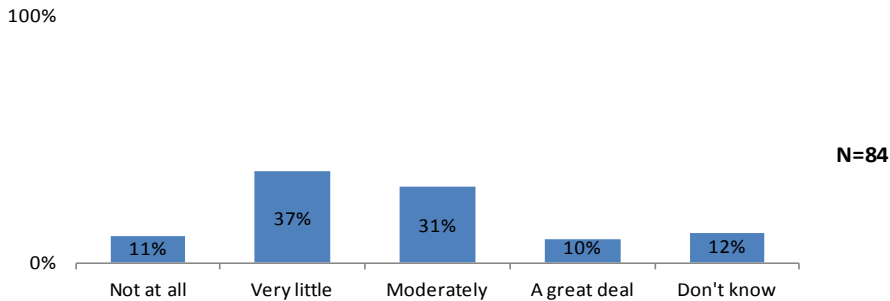
While nearly three-quarters of practices indicated they reviewed MaineCare UR reports, only half of respondents said their practice uses these reports to monitor quality for MaineCare patients, one third (32%) did not use them, and 12% responded that they did not know whether the practice used the reports.

Practice Use of MaineCare Utilization Review Reports to Monitor Quality for MaineCare Patients



Nearly half of practices (48%) indicated that the MaineCare UR performance measures had little or no influence on their practice operations. Thirty seven percent said it had very little influence and 11% said it did not influence them at all. Only 10% said UR measures influenced them a great deal, while 31% said it influenced them moderately.

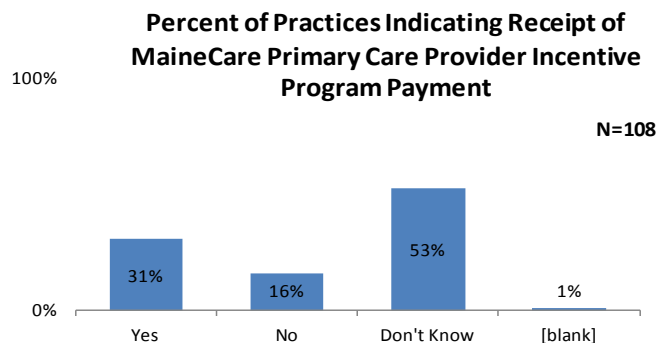
Extent of UR Report Influence on Practice Operations



MaineCare Primary Care Provider Incentive Payment Program

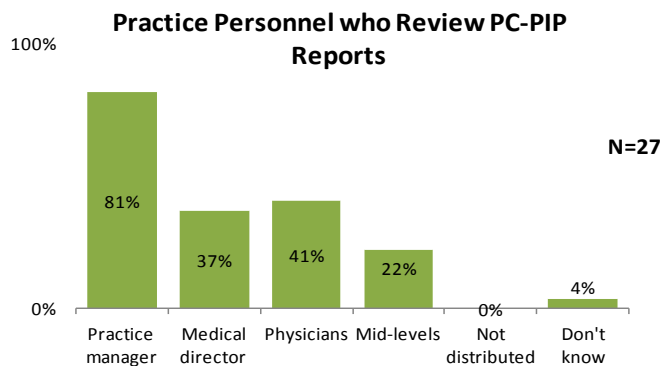
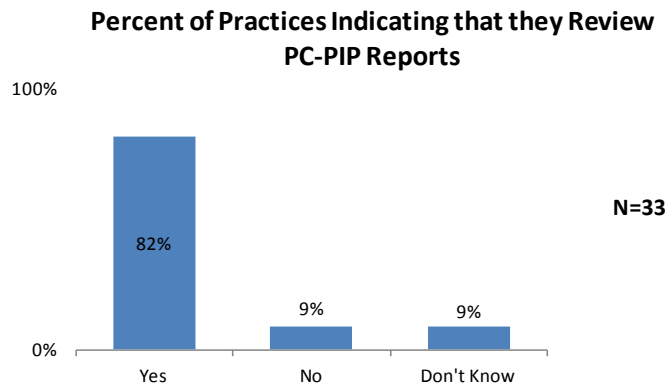
Since 1998, the MaineCare program has been offering payment incentives for eligible office-based practices through its Primary Care Provider Incentive Payment (PC-PIP) program. PC-PIP rewards eligible practices who have provided quality primary care to MaineCare members with the goals of increasing MaineCare members' access to care, reducing inappropriate emergency room utilization, and increasing the utilization of preventive and high quality services. The PC-PIP is available to office-based physician practices only.

Only 31% of responding pediatric and family practices indicated that they had received a PC-PIP incentive. The majority of responding practices (53%) did not know whether the practice had received PC-PIP incentive payments.



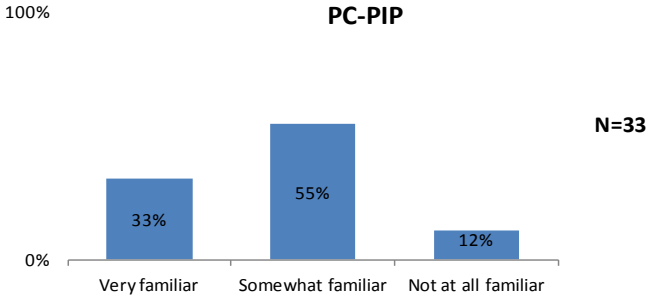
The remaining charts related to the PC-PIP reflect responses of only those practices that indicated they had

received an incentive (N=33). Within these practices, the vast majority indicated they reviewed PC-PIP reports. As with UR reports, most stated that the practice manager (81%) reviewed the PC-PIP report, followed by physicians (41%), medical director (37%), and mid-levels (22%).

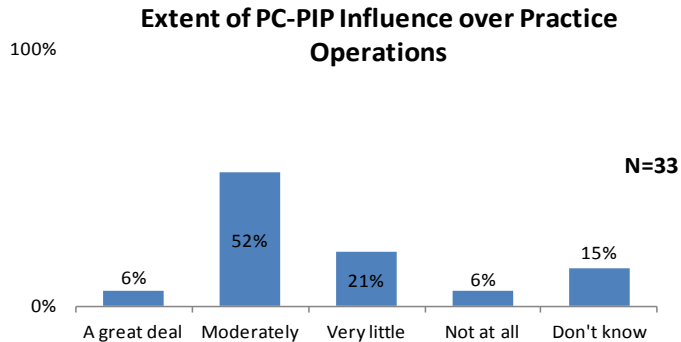


When asked about how familiar they are with the specific PC-PIP performance measures, 33% said they were very familiar, and 55% said they were somewhat familiar.

Practice Manager/Administrator Familiarity with PC-PIP

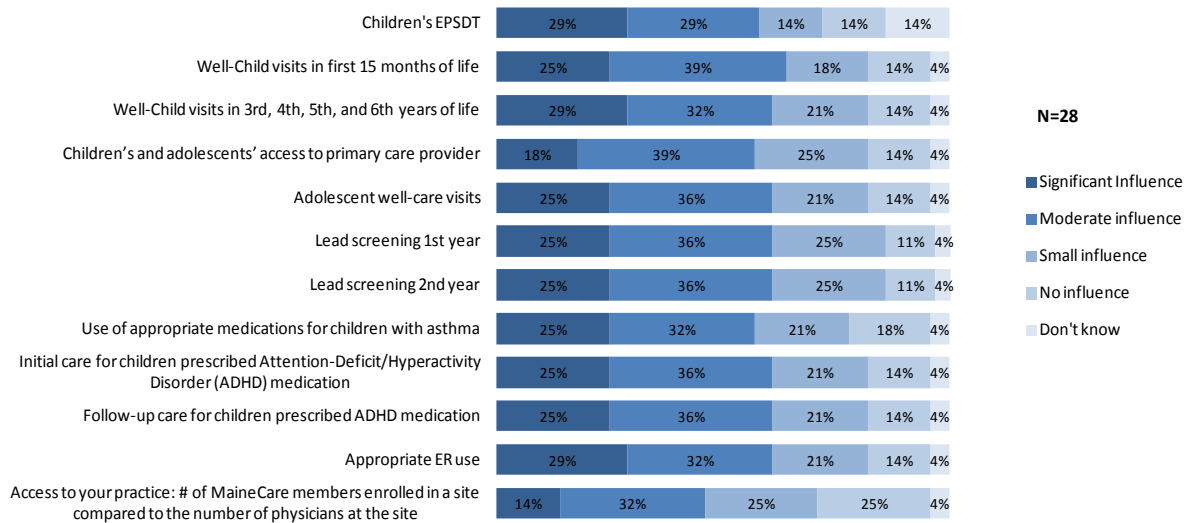


The PC-PIP had slightly more influence over practice operations than the UR reports, for responding practices; 58% of practices said the PC-PIP influenced their practice operations a great deal or moderately, compared to only 41% of practices for the UR reports.

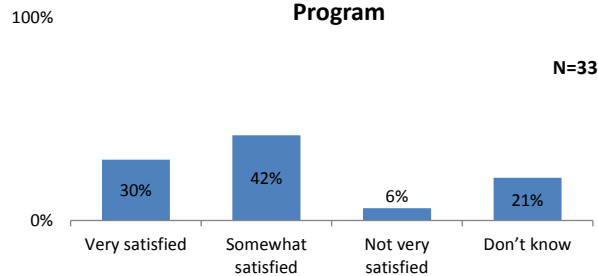


For specific PC-PIP measures, practices were even more likely to indicate a significant or moderate influence on practice operations. PC-PIP measures that practices were most likely to say significantly influenced their practice operations included well-child visits, children's EPSDT, and appropriate ER use. In general, most practices were very or somewhat satisfied with the PC-PIP; 32% were very satisfied and 41% were somewhat satisfied. Only 6% were not satisfied, and 21 % did not know.

Extent of Influence of PC-PIP on Management of MaineCare Members' Care



Overall Satisfaction with the MaineCare PC-PIP Program

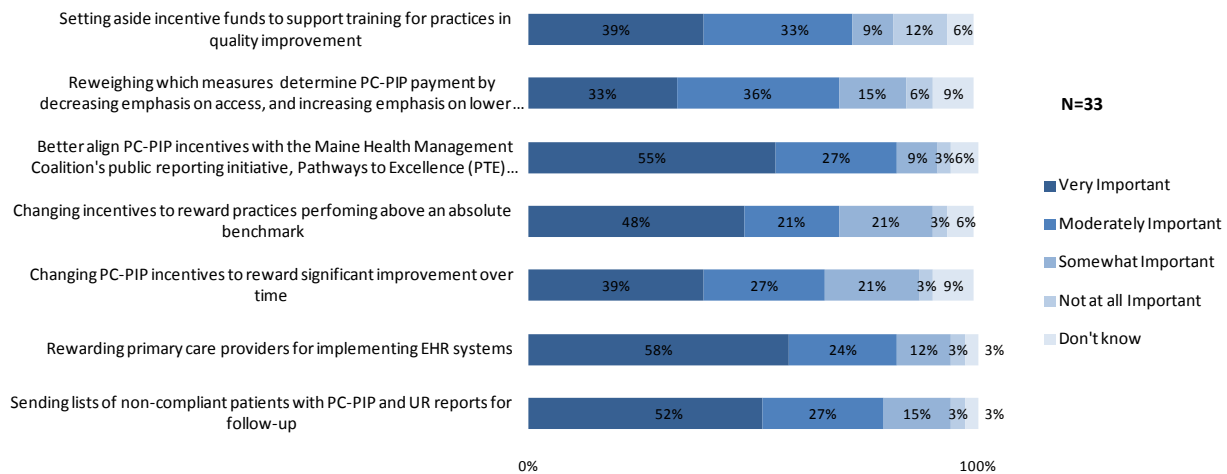


We also asked practices about potential modifications to the PC-PIP under consideration by the MaineCare program to get their feedback and assess how important they felt these changes would be to improving care for MaineCare members. The changes that were most important to responding practices (as represented by the total

percent indicating either ‘very’ or ‘moderately’ important) were:

- better align PC-PIP incentives with Pathways to Excellence (PTE) public reporting program,
- reward primary care providers for implementing electronic health record (EHR) systems, and
- send list of non-compliant patients with PC-PIP and UR reports to help them in following up with these members.

Respondents’ Views on Importance of Potential PC-PIP Modifications to Improving Care for MaineCare Members



Plans for Additional Analyses

The data contained in this Chartbook are intended to provide a snapshot of quality improvement activities and systems at Maine’s pediatric and family practices in early 2012. These data provide baseline information for the IHOC initiative and the state to inform future interventions and to evaluate the impact of IHOC on a state-wide-basis. Because a statewide survey of pediatric and family practices on these topics has not been reported previously, the data will likely be useful for additional purposes and by a variety of stakeholders.

A follow-up survey is scheduled for 2014 that will allow us to measure changes in pediatric quality improvement practice patterns and systems in Maine over time. Using statistical analyses, we will assess whether differences between practices participating in IHOC’s First STEPS initiative and those that do not participate are

statistically significant. These analyses are expected to provide information on whether the following quality improvement activities have increased over time and whether there are differences between First STEPS practices and others in:

- The extent to which practices use registries, EHRs, and targets in quality improvement efforts,
- The frequency with which practices perform selected quality improvement activities or standards of care including: checking immunizations systematically at all visits, using developmental and autism-specific screenings, and using anemia and lead screens/tests at appropriate ages,
- The prevalence of certain QI practices, such as tracking certain conditions with automated registries, and tracking/documenting Bright Futures standards of care,
- The overall use of Maine's immunization registry as well as specific registry features, and
- The extent to which practices are familiar with and use MaineCare quality reports and financial incentives to inform internal practice operations and improve care for children.

The follow-up survey will provide important information to the state about the potential impact of IHOC and First STEPS activities. This information is intended to be used in decision-making and policy setting related to child health care quality improvement; and to support the sustainability of effective and promising interventions. Survey results will also be shared with CHIPRA national evaluators and the Center for Medicare and Medicaid Services (CMS) to inform future federal quality improvement initiatives to improve health outcomes for low-income children covered by Medicaid and CHIP.

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